Exhibit B – Authorizations to Accompany Plaintiff Fact Sheet

- **Medical Records**
- **Mental Health Records**
- **Insurance Records**
- **Employment Records**
- **Education/Scholastic Records**
- **Social Security Disability Records**
- **Social Security Earnings Records**
- **Tax Records**

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA

CASE NO. 09-2051-MD-ALTONAGA/Brown

In RE
Denture Cream Products
Liability Litigation
_____/

AUTHORIZATION TO DISCLOSE HEALTH AND INSURANCE INFORMATION PURSUANT TO 45 CFR 164.508 (HIPAA)

TO: _____
Name of Healthcare Provider/Physician/Facility

_____
Address (Street, City, State, Zip Code

RE: Patient Name: _____
Date of Birth: _____ Social Security Number: _____-_____-_____
Address: _____

I, _____, hereby authorize you to release and furnish to *[Check one or both]*:

Stephanie A. Smith, Fulbright & Jaworski LLP (GSK) _____;
Frank C. Woodside III, Dinsmore & Shohl LLP (P&G) _____;

and/or her/his/their designated agent, **HG Litigation Services,** copies of full and complete protected medical and health information, including the following:

For use in the In Re Denture Cream Products Liability Litigation, MDL 2051. *To my healthcare provider: This authorization is forwarded by attorneys for defendant(s). This authorization permits you to release copies of records you made in connection with examinations, diagnosis and treatment of me; it does not permit you, nor does it authorize you, to speak to anyone concerning your care and treatment of me, unless you receive a separate and additional authorization permitting such discussion. Subject to all applicable legal objections, this restriction does not apply to discussing my medical history, care, treatment, diagnosis, prognosis, information revealed by or in the records, or any other matter bearing on my medical or physical condition at a deposition or trial.*

- All health information records, including medical, dental and medication records, inpatient, outpatient and emergency room treatment, all clinical charts, reports, order sheets, progress notes, nurse's notes, clinic records, treatment plans, admission records, discharge summaries, requests for and reports of consultations, documents, correspondence, test results, statements, questionnaires/histories, office and doctor's handwritten notes, and records received by other physicians or health care providers.

- All autopsy, laboratory, pathology, histology, cytology, hematology, radiology, CT scan, MRI, EMG, X-rays, Evoked Potentials Tests, SSEP tests, Nerve Conduction Velocity Studies (NCVS), echocardiogram and cardiac catheterization reports.

- All radiology films, CT scans, MRIs, Evoked Potentials tests, SSEP tests, Nerve Conduction Velocity Studies, X-rays, EMGs, mammograms, myelograms, photographs, bone scans, tracings, recordings, pathology/cytology/histology/autopsy/immunohistochemistry specimens, cardiac catheterization videos/CDs/films/reels, and echocardiogram videos.

- All pharmacy/prescription records including NDC numbers and drug information handouts/monographs

- All billing information, including all statements, itemized bills, insurance records and Medicare/Medicaid claims applications.

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment of alcohol and drug abuse.

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. *Unless otherwise revoked, this authorization will expire at conclusion of my involvement in the captioned litigation.*

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed as provided in 45 CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the releaser indicated above.

This authorization does not apply to psychotherapy notes, psychiatric or psychological records.

A notarized signature is <u>not</u> required. CFR 164.508. A facsimile or copy of this Authorization shall have the same force as an original.

I have read the above and authorize the disclosure of the protected health information as stated.

Patient Name [Please Print]	**Patient Signature**
Social Security Number	**Date**

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA

CASE NO. 09-2051-MD-ALTONAGA/Brown

In RE
Denture Cream Products
Liability Litigation
_____/

AUTHORIZATION FOR THE RELEASE OF MENTAL HEALTH RECORDS
PURSUANT TO 45 CFR 164.508(a) (2) (HIPAA)

TO: _____
Name of Mental Healthcare Provider/Physician/Facility

_____
Address (Street, City, State, Zip Code)

RE: Patient Name: _____
Date of Birth: _____ Social Security Number: _____-_____- _____
Address: _____

I, _____, hereby authorize you to release and furnish to *[Check one or both]*:

Stephanie A. Smith, Fulbright & Jaworski LLP (GSK) _____;
Frank C. Woodside III, Dinsmore & Shohl LLP (P&G)_____;

and/or her/his/their designated agent, **HG Litigation Services,** copies of full and complete protected medical and mental health information, including the following:

For use in the In Re Denture Cream Products Liability Litigation, MDL 2051. *To my healthcare provider: This authorization is forwarded by attorneys for defendant(s). This authorization permits you to release copies of records you made in connection with examinations, diagnosis and treatment of me; it does not permit you, nor does it authorize you, to speak to anyone concerning your care and treatment of me, unless you receive a separate and additional authorization permitting such discussion. Subject to all applicable legal objections, this restriction does not apply to discussing my medical history, care, treatment, diagnosis, prognosis, information revealed by or in the records, or any other matter bearing on my medical or physical condition at a deposition or trial.*

- All psychiatric, psychological or other confidential records relating to my emotional or other psychiatric/psychological condition for the purpose of review and evaluation in connection with a legal claim. I expressly request that the designated records custodian of all covered entities under HIPAA identified above disclose full and complete protected medical and mental information including the following:

  - All psychiatric/psychological records, including inpatient, outpatient and emergency room treatment, all clinical charts, reports, order sheets, progress notes, nurse's notes, clinic records, treatment plans, admission records, discharge summaries, requests for and reports of consultations, documents, correspondence, test results, statements, questionnaires/histories, records received by other physicians, pharmacy and prescription records, billing records and records of billing to third party payers and payment or denial of benefits.

This protected health information is disclosed for the following purposes: The currently pending litigation involving the person named above.

This authorization is given in compliance with 42 CFR 2.31, the restrictions of which have been specifically considered and expressly waived.

You are authorized to release the above records to the representatives of defendants noted above who have agreed to pay reasonable charges made by you to supply copies of such records.

I acknowledge that I have the right to revoke this authorization by written notification to you at the above referenced address. However, I understand that any actions already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
I acknowledge the potential for information disclosed pursuant to this authorization to be subject to redisclosure by the recipient and no longer be protected under 45 CFR 164.508.
I understand that the covered entity to whom this authorization is directed may not condition treatment, payment, enrollment or eligibility benefits on whether or not I sign the authorization.

I understand that the nature of this authorization is to authorize the release of my mental health records.

A notarized signature is not required. CFR 164.508. A facsimile, copy or photocopy of this Authorization shall have the same force as an original. *Unless otherwise revoked, this authorization shall expire at the conclusion of my involvement in the captioned litigation.*

I have read the above and authorize the disclosure of the protected mental health information as stated.

Patient Name [Please Print]	**Patient Signature**
Social Security Number	**Date**

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA

CASE NO. 09-2051-MD-ALTONAGA/Brown

In RE
Denture Cream Products
Liability Litigation
_____/

AUTHORIZATION FOR RELEASE OF INSURANCE RECORDS
Pursuant to 45 CFR 164 (HIPAA)

TO: _____
Name of Entity

_____
Address (Street, City, State, Zip Code)

RE: Plaintiff Name(s): _____ Policy No: _____

Date of Birth: _____ Social Security Number: _____-_____- _____

Insured Name(s) (if different):_____

I, _____, hereby authorize you to release and furnish to *[Check one or both]*:

Stephanie A. Smith, Fulbright & Jaworski LLP (GSK) _____;
Frank C. Woodside III, Dinsmore & Shohl LLP (P&G) _____;

and/or his/her/their designated agent, **HG Litigation Services,** all my insurance records, including the following:

- All information pertaining to my insurance, including but limited to, all forms and records regarding insurance claims applications and benefits and all medical, health, hospital, physicians, nursing or allied health professional reports, evaluations, records, notes or invoices and bills, which may be in your possession.

I understand that the information in my insurance records may include health information, information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

The release of the information listed above is being authorized for purposes of compliance with discovery in the captioned litigation. Any person, firm, or entity that releases information pursuant to this authorization is absolved from any liability that might otherwise result from the release of this information. I understand that I have the right to revoke this authorization at any time by providing to you a written revocation and I agree to simultaneously provide a copy of such revocation to the record requestors identified above. I also understand that any revocation will not apply to information that has already been released in response to this authorization. *Unless otherwise revoked, this authorization shall be continuing in nature and will expire at the conclusion of my involvement in the captioned litigation.*

I understand that authorizing the disclosure of this insurance information (and any health information contained therein) is voluntary. I can refuse to sign this authorization. I understand that treatment, enrollment, or eligibility for, or payment of, benefits may not be conditioned upon the signing of this authorization. I understand that I may inspect or copy the information to be used or disclosed as provided in 45 CFR 164.524. I understand that the released information may not be protected by federal privacy regulations and may be redisclosed in conjunction with this litigation.

This authorization does not apply to psychotherapy notes, psychiatric or psychological records.

A notarized signature is <u>not</u> required. 45 CFR 164.508. A facsimile, copy or photocopy of this Authorization shall have the same force as an original. This authorization complies with 45 CFR 164 regarding the core elements of an authorization pursuant to HIPAA.

I have read the above and authorize the disclosure of my insurance information (and any health information contained therein) as stated.

_____ _____

Plaintiff Name [Please Print] **Plaintiff Signature**

_____ _____

Social Security Number **Date**

Policy No._____

Insured Name (if different) _____
Policy/Group Id No._____

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA

CASE NO. 09-2051-MD-ALTONAGA/Brown

In RE
Denture Cream Products
Liability Litigation
_____/

AUTHORIZATION FOR RELEASE OF EMPLOYMENT/PAYROLL RECORDS

TO: _____
Name of Entity

_____
Address (Street, City, State, Zip Code)

RE: Plaintiff/Employee Name(s): _____
Date of Birth: _____ Social Security Number: _____-_____- _____

I, _____, hereby authorize you to release and furnish to *[Check one or both]*:

Stephanie A. Smith, Fulbright & Jaworski LLP (GSK) _____;
Frank C. Woodside III, Dinsmore & Shohl LLP (P&G)_____;

and/or his/her/their designated agent, **HG Litigation Services,** all my employment/personnel/payroll records, including the following:

- All information, including but not limited to any and all employment records, personnel records, applications for employment, W-2 forms, documents related to the beginning of and termination of employment, employee performance evaluations, payroll records, vacation and illness benefits and use, reprimand/commendation notices, and all other documents, papers, checks and ledgers showing wages, salaries, other earnings and employee benefits, and the amount of time and number of days worked.

The release of the information listed above is being authorized for purposes of compliance with discovery in the captioned litigation. Any person, firm, or entity that releases information pursuant to this authorization is absolved from any liability that might otherwise result from the release of this information. I understand that I have the right to revoke this authorization at any time by providing to you a written revocation and agree to simultaneously provide a copy of such revocation to the record requestors identified above. I also understand that any revocation will not apply to information that has already been released in response to this authorization. *Unless otherwise revoked, this authorization shall be continuing in nature and will expire at the conclusion of my involvement in the captioned litigation.*

A notarized signature is <u>not</u> required. A facsimile, copy or photocopy of this Authorization shall have the same force as an original.

I have read the above and authorize the disclosure of my employment/payroll/personnel information as stated.

_____ _____
Plaintiff/Employee [Please Print] **Signature**

_____ _____
Social Security Number **Date**

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA

CASE NO. 09-2051-MD-ALTONAGA/Brown

In RE
Denture Cream Products
Liability Litigation
_____/

AUTHORIZATION FOR RELEASE OF SCHOLASTIC/EDUCATION RECORDS

TO: _____
Name of Entity

_____
Address (Street, City, State, Zip Code)

RE: Plaintiff Name(s): _____
Date of Birth: _____ Social Security Number: _____-_____- _____

I, _____, hereby authorize you to release and furnish to *[Check one or both]*:

Stephanie A. Smith, Fulbright & Jaworski LLP (GSK) _____;
Frank C. Woodside III, Dinsmore & Shohl LLP (P&G)_____;

and/or his/her/their designated agent, **HG Litigation Services,** my education and scholastic records, as follows:

- Dates of attendance at your school/institution and any diplomas, certificates or degrees obtained.

The release of the information listed above is being authorized for purposes of compliance with discovery in the captioned litigation. Any person, firm, or entity that releases information pursuant to this authorization is absolved from any liability that might otherwise result from the release of this information. I understand that I have the right to revoke this authorization at any time by providing to you a written revocation and agree to simultaneously provide a copy of such revocation to the record requestors identified above. I also understand that any revocation will not apply to information that has already been released in response to this authorization. *Unless otherwise revoked, this authorization shall be continuing in nature and will expire at the conclusion of my involvement in the captioned litigation.*

A notarized signature is not required. A facsimile, copy or photocopy of this Authorization shall have the same force as an original.

I have read the above and authorize the disclosure of my education and scholastic information as stated.

_____ _____
Plaintiff Name [Please Print] **Signature**

_____ _____
Social Security Number **Date**

Form Approved
OMB No. 0960-0566

Social Security Administration
Consent for Release of Information

Please read these instructions carefully before completing this form.

When to Use This Form

Complete this form only if you want the Social Security Administration to give information or records about you to an individual or group (for example, a doctor or an insurance company).

Natural or adoptive parents or a legal guardian, acting on behalf of a minor, who want us to release the minor's:

- **nonmedical** records, should use this form.
- medical records, should not use this form, but should contact us.

Note: Do not use this form to request information about your earnings or employment history. To do this, complete Form SSA-7050-F4. You can get this form at any Social Security office.

How to Complete This Form

This consent form must be completed and signed only by:

- the person to whom the information or record applies, or
- the parent or legal guardian of a minor to whom the **nonmedical** information applies, or
- the legal guardian of a legally incompetent adult to whom the information applies.

To complete this form:

- Fill in the name, date of birth, and Social Security Number of the person to whom the information applies.
- Fill in the name and address of the individual or group to which we will send the information.
- Fill in the reason you are requesting the information.
- Check the type(s) of information you want us to release.
- Sign and date the form. If you are not the person whose record we will release, please state your relationship to that person.

PRIVACY ACT NOTICE: The Privacy Act Notice requires us to notify you that we are authorized to collect this information by section 3 of the Privacy Act. You do not have to provide the information requested. However, we cannot release information or records about you to another person or organization without your consent for release of information. Your records are confidential. We will release only records that you authorize, and only to persons or organizations who you authorize to receive that information.

PAPERWORK REDUCTION ACT STATEMENT: This information collection meets the clearance requirements of 44 U.S.C. §3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 3 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. The office is listed under U.S. Government agencies in your telephone directory or you may call Social Security at 1-800-772-1213.** *You may send comments on our time estimate above to: SSA, 6401 Security Blvd., Baltimore, MD 212345-6401. Send only comments relating to our time estimate to this address, not the completed form.*

Form Approved
OMB No. 0960-0566

Social Security Administration

Consent for Release of Information

TO: Social Security Administration

Name	Date of Birth	Social Security Number

I authorize the Social Security Administration to release information or records about me to:

NAME	ADDRESS

I want this information released because:

(There may be a charge for releasing information.)

Please release the following information:

XX Social Security Number
XX Identifying information (includes date and place of birth, parents' names)
XX Monthly Social Security benefit amount
XX Monthly Supplemental Security Income payment amount
XX Information about benefits/payments I received from _____ to _____
XX Information about my Medicare claim/coverage from _____ to _____
XX (specify) _____
XX Medical records
XX Record(s) from my file (specify) Entire file is requested
_____ Other (specify) _____

I am the individual to whom the information/record applies or that person's parent (if a minor) or legal guardian. I know that if I make any representation which I know is false to obtain information from Social Security records, I could be punished by a fine or imprisonment or both.

Signature: _____
(Show signatures, names, and addresses of two people if signed by mark.)
Date: _____ Relationship: _____

Form **SSA-3288** (5-2007) EF (5-2007)

Form Approved
OMB No. 0960-0525

REQUEST FOR SOCIAL SECURITY EARNINGS INFORMATION

*Use This Form If You Need

1. **Certified/Non-Certified Detailed Earnings Information**

   Includes periods of employment or self-employment and the names and addresses of employers.

OR

2. **Certified Yearly Totals of Earnings**

   Includes total earnings for each year but does not include the names and addresses of employers.

DO NOT USE THIS FORM FOR:

Non-certified yearly totals of earnings

This service is free to the public.

These totals can be obtained by calling 1-800-772-1213 to receive Form SSA-7004, Request for Earnings and Benefit Estimate Statement.

PRIVACY ACT NOTICE: We are authorized to collect this information under section 205 of the Social Security Act, and the Federal Records Act of 1950 (64 Stat. 583). It is needed so we can identify your records and prepare the statement you request. You do not have to furnish the information, but failure to do so may prevent your request from being processed.

PAPERWORK REDUCTION ACT: This information collection meets the clearance requirements of 44 U.S.C. §3507, as amended by Section 2 of the Paperwork Reduction Act of 1995. You are not required to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take you about 11 minutes to read the instructions, gather the necessary facts, and answer the questions.

INFORMATION ABOUT YOUR REQUEST

- **How Do I Get This Information?**

  You need to complete the attached form to tell us what information you want.

- **Can I Get This Information For Someone Else?**

  Yes, if you have their written permission. For more information, see page 3.

- **Who Can Sign On Behalf Of The Individual?**

  The parent of a minor child, or the legal guardian of an individual who has been declared legally incompetent, may sign if he/she is acting on behalf of the individual.

- **Is There A Fee For This Information?**

  1. **Certified/Non-Certified Detailed Earnings Information**

     Yes, we usually charge a fee for detailed information. In most cases, this information is used for purposes NOT directly related to Social Security such as for a private pension plan or personal injury suit. The fee chart on page 3 gives the amount of the charge.

     Sometimes, there is no charge for detailed information. If you have reason to believe your earnings are not correct (for example, you have previously received earnings information from us and it does not agree with your records), we will supply you with more detail for the period in question. Occasionally, earnings amounts are wrong because an employer did not correctly report earnings or earnings are credited to the wrong person. In situations like these, we will send you detailed information, at no charge, so we can correct your record.

     Be sure to show the year(s) involved on the request form and explain why you need the information. If you do not tell us why you need the information, we will charge a fee.

     We will certify the detailed earnings information for an additional fee of $15.00. Certification is usually not necessary unless you plan to use the information in court.

  2. **Certified Yearly Total of Earnings**

     Yes, there is a fee of $15 to certify yearly totals of earnings. Cetification is usually not necessary unless you plan to use the information in court.

  3. **Method of Payment**

     Enclose a check or money order for the entire fee required. Payment can also be made by credit card. To do so, complete page 4 of this form and return it with your request form.

REQUEST FOR SOCIAL SECURITY EARNINGS INFORMATION

1. From whose record do you need the earnings information?

Print the Name, Social Security Number (SSN), and date of birth below.

Name _____ Social Security Number _____

Other Name(s) Used (Include Maiden Name) _____ Date of Birth (Mo/Day/Yr) _____

2. What kind of information do you need?

☐ **Detailed Earnings Information** (If you check this block, tell us below why you need this information.) For the period(s)/year(s): _____

_____

_____

☐ **Certified Total Earnings For Each Year.** (Check this box only if you want the information certified. Otherwise, call 1-800-772-1213 to request Form SSA-7004, Request for Earnings and Benefit Estimate Statement) For the year(s): _____

3. If you owe us a fee for this detailed earnings information, enter the amount due using the chart on page 3 . . . . . A. $ _____

Do you want us to certify the information? ☐ Yes ☐ No

If yes, enter $15.00 . . . . . B. $ _____

ADD the amounts on lines A and B, and enter the TOTAL amount . . . . . C. $ _____

- You can pay by CREDIT CARD by completing and returning the form on page 4, or
- Send your CHECK or MONEY ORDER for the amount on line C with the request and make check or money order payble to "Social Security Administration"
- DO NOT SEND CASH.

4. I am the individual to whom the record pertains (or a person who is authorized to sign on behalf of that individual). I understand that any false representation to knowingly and willfully obtain information from Social Security records is punishable by a fine of not more than $5,000 or one year in prison.

SIGN your name here (Do not print) > _____ Date _____

Daytime Phone Number _____ _____ (Area Code) (Telephone Number)

5. Tell us where you want the information sent. (Please print)

Name _____ Address _____

City, State & Zip Code _____

6. Mail Completed Form(s) To:

Social Security Administration
Division of Earnings Record Operations
P.O. Box 33003
Baltimore Maryland 21290-3003

Exception: If using private contractor (e.g., FedEx) to mail form(s), use:

Social Security Administration
Division of Earnings Record Operations
300 N. Greene St.
Baltimore Maryland 21290-0300

REQUEST FOR SOCIAL SECURITY EARNINGS INFORMATION

How Much Do I Have to Pay For Detailed Earnings?

1. Count the number of years for which you need detailed earnings information. Be sure to add in both the first and last year requested. However, do not add in the current calendar year since this information is not yet available.

2. Use the chart below to determine the correct fee.

Number of Years Requested	Fee	Number of Years Requested	Fee	Number of Years Requested	Fee
1	$15.00	15	$43.75	28	$64.50
2	17.50	16	45.50	29	66.00
3	20.00	17	47.25	30	67.50
4	22.50	18	49.00	31	68.75
5	25.00	19	50.75	32	70.00
6	27.00	20	52.50	33	71.25
7	29.00	21	54.00	34	72.50
8	31.00	22	55.50	35	73.75
9	33.00	23	57.00	36	75.00
10	35.00	24	58.50	37	76.25
11	36.75	25	60.00	38	77.50
12	38.50	26	61.50	39	78.75
13	40.25	27	63.00	40	80.00
14	42.00				

For Requests Over 40 Years, Please Add 1 Dollar for Each Additional Year.

- **Whose Earnings Can Be Requested**

1. Your Earnings

You can request earnings information from your own record by completing the attached form; we need your handwritten signature. If you sign with an "X", your mark must be witnessed by two disinterested persons who must sign their name and address.

2. Someone Else's Earnings

You can request earnings information from the record of someone else if that person tells us in writing to give the information to you. This writing or "authorization" must be presented to us within 60 days of the date it was signed by that person.

3. A Deceased Person's Earnings

You can request earnings information from the record of a deceased person if you are the legal representative of the estate, a survivor (that is, the spouse, parent, child, divorced spouse of divorced parent), or an individual with a material interest (example-financial) who is an heir at law, next of kin, beneficiary under the will or donee of property of the decedent.

Proof of death must be included with your request. Proof of appointment as representative or proof of your relationship to the deceased must also be included.

YOU CAN MAKE YOUR PAYMENT BY CREDIT CARD

As a convenience, we offer you the option to make your payment by credit card. However, regular credit care rules will apply. You may also pay by check or money order.

We Only Accept MasterCard and Visa

Please fill in all the information below and return this form along with your request to:

Social Security Administration
Division of Earnings Record Operations
P.O. Box 33003
Baltimore Maryland 21290-3003

Exception:
If using private contractor (e.g., FedEx) to mail form(s), use:

Social Security Administration
Division of Earnings Record Operations
300 N. Greene St.
Baltimore Maryland 21290-0300

Note: Please read Paperwork/Privacy Act Notice

NUMBER HOLDER'S SSN ——→ *(If more than one request, only list one SSN)*	___ ___ ___
CHECK ONE ——→	☐ MasterCard ☐ VISA
Credit Card Holder's Name ——→ (Enter the name from the credit card)	First, Middle Initial, Last Name
Credit Card Holder's Address ——→	Number & Street City, State, Zip Code
Daytime Telephone Number ——→	___ ___ Area Code Telephone Number
Amount Charged $ _____	Credit Card Number ___ - ___ - ___ - ___
Credit Card Holder's Signature ——→	Credit Card Expiration Date Month | Year
DO NOT WRITE IN THIS SPACE OFFICE USE ONLY	Authorization Name | Date

PRIVACY ACT NOTICE

The Social Security Administration (SSA) has authority to collect the information requested on this form under section 205 of the Social Security Act. Giving us this information is voluntary. You do not have to do it. We will need this information only if you choose to make payment by credit card. You do not need to fill out this form if you choose another means of payment (for example, by check or money order).

If you choose the credit card payment option, we will provide the information you give us to the banks handling your credit card account and SSA's account. We may also provide this information to another person or government agency to comply with federal laws requiring the release of information from our records. You can find these and other routine uses of information provided to SSA listed in the Federal Register. If you want more information about this, you may call or write any Social Security Office.

Form **4506**

(Rev. November 2005)

Department of the Treasury
Internal Revenue Service

Request for Copy of Tax Return

▶ **Do not sign this form unless all applicable lines have been completed. Read the instructions on page 2.**

▶ **Request may be rejected if the form is incomplete, illegible, or any required line was blank at the time of signature.**

OMB No. 1545-0429

Tip: You may be able to get your tax return or return information from other sources. If you had your tax return completed by a paid preparer, they should be able to provide you a copy of the return. The IRS can provide a **Tax Return Transcript** for many returns free of charge. The transcript provides most of the line entries from the tax return and usually contains the information that a third party (such as a mortgage company) requires. See **Form 4506-T,** Request for Transcript of Tax Return, or you can call 1-800-829-1040 to order a transcript.

1a Name shown on tax return. If a joint return, enter the name shown first.	**1b First social security number on tax return or employer identification number (see instructions)**
2a If a joint return, enter spouse's name shown on tax return	**2b Second social security number if joint tax return**

3 Current name, address (including apt., room, or suite no.), city, state, and ZIP code

4 Previous address shown on the last return filed if different from line 3

5 If the tax return is to be mailed to a third party (such as a mortgage company), enter the third party's name, address, and telephone number. The IRS has no control over what the third party does with the tax return.

Caution: *If a third party requires you to complete Form 4506,* ***do not*** *sign Form 4506 if lines 6 and 7 are blank.*

6 **Tax return requested** (Form 1040, 1120, 941, etc.) and all attachments as originally submitted to the IRS, including Form(s) W-2, schedules, or amended returns. Copies of Forms 1040, 1040A, and 1040EZ are generally available for 7 years from filing before they are destroyed by law. Other returns may be available for a longer period of time. Enter only one return number. If you need more than one type of return, you must complete another Form 4506. ▶ _____

Note. *If the copies must be certified for court or administrative proceedings, check here.* . . . . . ☐

7 **Year or period requested.** Enter the ending date of the year or period, using the mm/dd/yyyy format. If you are requesting more than eight years or periods, you must attach another Form 4506.

/ /	/ /	/ /	/ /
/ /	/ /	/ /	/ /

8 **Fee.** There is a $39 fee for each return requested. **Full payment must be included with your request or it will be rejected. Make your check or money order payable to "United States Treasury." Enter your SSN or EIN and "Form 4506 request" on your check or money order.**

a	Cost for each return	$ 39.00
b	Number of returns requested on line 7	
c	Total cost. Multiply line 8a by line 8b	$

9 If we cannot find the tax return, we will refund the fee. If the refund should go to the third party listed on line 5, check here . . ☐

Signature of taxpayer(s). I declare that I am either the taxpayer whose name is shown on line 1a or 2a, or a person authorized to obtain the tax return requested. If the request applies to a joint return, **either** husband or wife must sign. If signed by a corporate officer, partner, guardian, tax matters partner, executor, receiver, administrator, trustee, or party other than the taxpayer, I certify that I have the authority to execute Form 4506 on behalf of the taxpayer.

Sign Here

▶ **Signature** (see instructions)	Date	Telephone number of taxpayer on line 1a or 2a ( )
▶ **Title** (if line 1a above is a corporation, partnership, estate, or trust)		
▶ **Spouse's** signature	Date	